Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Uday V Doctor

Respondent Name
Sunbelt Insurance Co

MFDR Tracking Number
M4-07-6085-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 16, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "They had the claim originally on 10-18-06 when we called for status. Please reprocess this claim as the claim was received before the deadline."

Amount in Dispute: $348.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: From Highlands Insurance Company, 11/28/11: "Please be advised that the Carrier did not have a contract with the network or a contract with the medical provider. All bills were audited based on the statutory medical fee guidelines. In this particular dispute, payment was denied based on untimely filing of a completed medical bill."

From Beverly L. Vaughn, June 6, 2007: "The provider's request for reconsideration, with attached operative report, was not received by the carrier until 03/16/07. It is clear from the fax notation at the top of the operative report, both on the copy received by the carrier on 3/16/07 and the copy submitted by the provider with the medical dispute, that the provider did not obtain a copy of the operative report until 3/16/07 and then faxed a copy of it to the carrier. Because the required documentation for the bill was received outside of the 95 days, the provider did not submit its bill timely.

Response Submitted by: Highlands Insurance Company, PO Box 42307 Houston, TX
Beverly L. Vaughn, SS01 – A Balcones Drive #104/Austin, Texas 78731

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2006	Physician Services	$348.06	$348.06

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services
3. 28 Texas Administrative Code §133.20 sets out the requirements for medical bill submission by health care

providers.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired
   - 45 – Chares exceed your contracted/legislated fee
   - 16 – Claim/service lacks information which is needed for adjudication

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Was the claim submitted in compliance with Division rules and guidelines?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. 28 Texas Administrative Code §133.20(b) states in pertinent part, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Review of the submitted documentation finds the following
   a. Date of bill creation 09/15/ 2006, in box 31 of CMS 1500
   b. Date of original bill review by Carrier, 10/11/2006

   The Division finds requirements of 133.210(b)(2) were met as the claim was submitted within 95 of the date of service September 8, 2006.
3. 28 Texas Administrative Code §134.202 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section. " and (c) states in pertinent part, "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. The calculations for the services in dispute is as follows;

Date of Service	Submitted Code	Billed Amount	MAR Physician Fee Schedule Amount for Houston, TX x 125%
September 6, 2006	64483	775.00	382.53 x 125% = $478.16
September 6, 2006	64484	550.00	181.67x 125% = $227.09
September 6, 2006	76005 26, 69	150.00	(Per Medicare NCCI edits not separately reportable)
September 6, 2006	76005 26, 76, 59	150.00	(Per Medicare NCCI edits not separately reportable)
		$1625.00	$705.25

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. The total MAR is $705.25. The requestor is seeking 348.06. This amount is recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $348.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Peggy Miller	August 21, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.